SAINI ORTHODONTICS

10776 Hickory Ridge Road
Columbia, MD 21044
"Getting To Know You"

For Patients under Age 18 years

Patient's Full Name: _____ Sex: __Female __Male Birth Date: _____ Age: _____

Patient's Address: _____ City: _____ State: _____

Zip/Postal Code: _____ Home Phone: _____ Cell Phone: _____

Attends School At: _____ Grade: _____ Nickname: _____ Hobbies/Activities: _____

PARENT/GUARDIAN

Father's Full Name: _____ Title: __Mr. __Dr. Other: _____

Address (if different than patient's): _____ City: _____ State: _____

Zip/Postal Code: _____Home Phone: _____ Cell Phone:_____

Occupation: _____ Position: _____ Email: _____

Ok to call you at work: __YES __NO Work Phone: _____

Mother's Full Name: _____ Title: __Mrs. __Ms. __Dr. Other: _____

Address (if different than patient's): _____ City: _____ State: _____

Zip/Postal Code: _____ Home Phone: _____ Cell Phone: _____

Occupation: _____ Position: _____ Email: _____

Ok to call you at work: __YES __NO Work Phone: _____

Person responsible for financial account: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____

Zip/Postal Code: _____ Home Phone: _____

Dental Insurance Company: _____ ID # _____ Group # _____

Primary Holder's Full Name: _____ Birth Date: _____

Does this policy have orthodontic benefit? __YES __NO

Secondary Dental Insurance Company: _____ ID # _____ Group# _____

Secondary Holder's Full Name: _____ Birth Date: _____

Does this policy have orthodontic benefit? __YES __NO

How did you become aware of this office? _____

Patient's Height: _____ Father's Height: _____ Mother's Height: _____

Brothers' Ages: _____ Sisters' Ages: _____ Patient Adopted: __YES __NO

Parent's: __Single __Married __Separated __Divorced

Previous Orthodontic Experience: __Father __Mother __Brother __Sister __Patient Where: _____

DENTIST

Patient's Dentist: _____ Last visit to DDS (months): _____ Last X-Ray (months): _____

Address: _____City: _____ State: _____

Zip/Postal Code: _____ Phone: _____ General Oral Health: _____

PHYSICIAN

Patient's Physician: _____ Phone # _____

MEDICAL HISTORY

__YES __NO Are you presently under a physician's care? If so, for what: _____

__YES __NO Have you ever been hospitalized? If so, for what: _____

__YES __NO Has there been any change in your health this year?

__YES __NO Have you ever been advised to premedicate with antibiotics for dental appointments? _____

__YES __NO Prior adverse dental experiences Patient_____ Parent_____ Siblings_____

__YES __NO Operations If so, for what? _____

__YES __NO Adenoid Removed

__YES __NO Tonsils Removed

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING PROBLEM?

__YES __NO Endocrine/Thyroid problems

__YES __NO Diabetes

__YES __NO Heart trouble or stroke

__YES __NO Do you wear a pacemaker?

__YES __NO Heart murmur, Mitral Valve Prolapse/Rheumatic Fever

__YES __NO Do you have cardiac valve prosthesis?

__YES __NO High or low blood pressure

__YES __NO Chest pains, ankle swelling, or shortness of breath

__YES __NO Clotting problems, blood transfusions

__YES __NO Epilepsy or seizures, fainting

__YES __NO Glaucoma or eye disorders

__YES __NO Do you wear contacts?

__YES __NO Tested positive to the HIV virus/AIDS/STD?

__YES __NO Transplants or any artificial prosthesis

__YES __NO Medical radiation/chemotherapy treatments

__YES __NO Neurological problems

__YES __NO Depression or Anxiety

__YES __NO Sleep Apnea

__YES __NO Kidney problems, dialysis

__YES __NO Hepatitis, jaundice, or liver disease

__YES __NO Arthritis, rheumatism

__YES __NO Abnormal bleeding or blood disorders

__YES __NO Stomach or duodenal ulcers

__YES __NO Asthma, allergies, respiratory problems

__YES __NO Tuberculosis

__YES __NO Any other medical problems/operations?

_____

_____

ARE YOU ALLERGIC TO OR REACT ADVERSLY TO:

__YES __NO Local Anesthetics (Novocaine)

__YES __NO Motrin, Advil (Ibuprofen), Aspirin, Tylenol

__YES __NO Barbiturates, sedatives, sleeping pills

__YES __NO Other: _____

__YES __NO Latex, nickel

__YES __NO Penicillin, other antibiotics

__YES __NO Codeine

ARE YOU PRESENTLY TAKING ANY OF THE FOLLOWING MEDICIATIONS?

__YES __NO Antibiotics _____

__YES __NO Tranquilizers _____

__YES __NO Medication for high blood pressure _____

__YES __NO Aspirin _____

__YES __NO Nitroglycerin _____

__YES __NO Digitalis or other heart medication _____

__YES __NO Osteoporosis medicines (Bisphosphonate, etc.)

__YES __NO Anticoagulants (Blood Thinners)

__YES __NO Cortisone (steroids)

__YES __NO Medication for diabetes _____

__YES __NO Ritalin, Prozac, other _____

__YES __NO Any substance abuse problem?

__YES __NO Are you presently taking any other prescription medications/nonprescription? If yes, please list:

_____

Learning Disability: __YES __NO ADD/ADHD: __YES __NO Autism: __YES __NO

Menarche/Puberty: __YES __NO

DENTAL HISTORY

Any Facial/Dental Injuries? __YES __NO What kind? _____

Does the Patient play a Musical Instrument? __YES __NO What kind? _____

Does the Patient have difficulty closing lips or biting with front teeth? __YES __NO

Oral Habits: __Thumb sucking __Finger sucking __Nail biting __Lip biting __Mouth-breathing

__Tongue thrust __Snoring

Tooth eruption rate: __Normal __Late __Accelerated

Gag Reflex: __None __Moderate __Strong

Speech and other problems: _____

Who noticed the need for Orthodontic treatment first? __Patient __Parents __Dentist Other: _____

Pervious Orthodontic Treatment: __YES __ NO Length of Treatment _____ Mos. _____

Orthodontist: _____ Previous Orthodontic Consultation? __YES __NO

TMJ HISTORY

Any pain in joints/jaw?	__YES	__NO	Frequent Headaches?	__YES	__NO
Any popping or clicking of the jaw joints?	__YES	__NO	Pain/Ringing/Fullness in ear?	__YES	__NO
Grinding or clenching of teeth?	__YES	__NO	Pain or soreness in the eyes?	__YES	__NO
Is there any tightness of jaws-joints?	__YES	__NO	Neck or shoulder pain?	__YES	__NO
Is there any difficulty swallowing?	__YES	__NO	Difficultly in opening mouth?	__YES	__NO

GENERAL INFORMATION

Is Patient Sensitive? __YES __NO Reserved: __YES __NO Outgoing: __YES __NO

What do you think is wrong with patient's teeth? _____

What are your expectations? _____

PERSON FILLING OUT PAPERWORK

Name: _____ Relationship to patient: _____

***If other than parent, Legal Guardianship paperwork is required before any treatment can be rendered.**

For your information:
Some of the orthodontic appointments will infringe on school/work time.
Possible side effects of orthodontics – cavities, enlargement of gums, root shortening, bone loss, joint disturbances and relapse.
Benefits of Orthodontics – Esthetics, health, function and comfort.

I, the undersigned, have given the above dental and medical information, have reviewed it and find it accurate. If there are any changes later on to this history record, I will so inform this practice. Also, I give consent for this examination and am legally authorized to do so.

_____ _____

REVIEWED BY DATE SIGNATURE (PARENT – LEGAL GUARDIAN) DATE